



State of Wisconsin
Department of Workforce Development (DWD)
Bureau of Migrant, Refugee and Labor Services

Family Self-Sufficiency Plan (FSP)

- I. Family Intake Form**
- II. Individual Assessment Form**
- III. Employability Development Plan (EDP)**

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Updated August 29, 2002

State of Wisconsin
Department of Workforce Development (DWD)
(Updated-August 29, 2002)

<i>Refugee Employment Services</i>

At a minimum, each case file must contain the following information:

1. A FAMILY SELF-SUFFICIENCY PLAN (FSP) or a plan that includes:
 - (a) An Intake Form for the Family
 - (b) An Assessment Form for Each Adult Family Member
 - (c) An Employability Development Plan (EDP) for each adult family member (may substitute Wisconsin Works (W-2 EDP))
 - (d) A copy of the client's I-94 card.
 - (e) Document the alien number.
 - (f) Employment related records, (documenting follow-up services and 90 day employment verification)
 - (g) Case notes
2. Other documents may be included in the case file, including:
 - (a) Other support forms that may be developed by the agency for its own use (for example, a Referral Form (both in-house and to other providers) or a report to the County/W-2 agency re: client obtained employment
 - (b) Health related records
 - (c) Copy of the Social Security Card (especially in the case of secondary migrants)

(Enter your Agency Name Here)
Refugee Services
Family self-sufficiency Plan (FSP)

I. Family Intake Form

Date	Worker (Case Manager)
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A. Family Information

(1) Name of Head of Household:		(2) Social Security #:	
(3) Date of Birth:		(4) Telephone:	
(5) Alien Number:	(6) Nationality:	(7) VOLAG (Voluntary Agency) involved in the resettlement <input type="checkbox"/> Catholic Charities of Green Bay <input type="checkbox"/> Catholic Charities of Milwaukee <input type="checkbox"/> Jewish Family Services <input type="checkbox"/> Jewish Social Services <input type="checkbox"/> Lutheran Social Services <input type="checkbox"/> Other (enter name) _____	(8) Date of arrival in U.S. (9) Date of arrival to Wisconsin
(10) Monthly Income <input type="checkbox"/> RCA _____ <input type="checkbox"/> W-2 _____ <input type="checkbox"/> Employment _____ <input type="checkbox"/> SSI _____ <input type="checkbox"/> Other _____ Total _____	(11) W-2 Agency contact (Financial Employment Planner) (enter name & phone number) (12) Length of time on W-2 or RCA: (13) Supportive Services Planner (enter name & telephone number)		(14) Health coverage. Enter the types of health coverage the family is participating in <input type="checkbox"/> RMA <input type="checkbox"/> MA/BadgerCare <input type="checkbox"/> Employer sponsored HMO <input type="checkbox"/> Privately purchased

I. Family Intake Form, continued

B. Household Information Enter each member of the household, and record their current activities.

Name	Relationship to head of household	Employed (enter name of the employer)	If not employed, indicate the type of position the jobseeker wants	Enrolled in ESL (enter where)	Skills Training (enter where)	School (enter the school name)	U.S. Citizen (enter date citizenship is acquired)

Additional Comments/Information: (Note: Attach a copy of VOLAG plan, if appropriate)

(Enter Refugee Agency Name here)
Refugee Employment Services
Family Self-sufficiency Plan (Continued)

II. ASSESSMENT FORM

Note: Please complete a separate Assessment Form for each adult family member

A. GENERAL INFORMATION

(1) Client name	
(2) Telephone # (if different than listed above)	
(3) Current employer	
(4) Current wage:	
(5) Job Upgrade (if applicable) What type of position are you interesting in obtaining	

II. Assessment Form, continued

B. EDUCATION & EMPLOYMENT BACKGROUND

(1) Education. How many years of education do you have in your native country?		
(2) How many years of education do you have in the U.S.?		
(3) What was your area of study?		
(4) What diplomas or certificates did you receive? (Identify by name)		
(5) List any other schooling.		
(6) Have you received skills training in a specialized occupational area? (enter type)		
(7) Enter the school name and length of skill training program (if applicable)		
(8) Are you presently enrolled in vocational training? If so, enter type of training, the organization sponsoring the training, and the start and end dates of the training.		
(9) Are you presently enrolled in an ESL class? Enter the name of the organization conducting the training, and your current ESL level	<input type="checkbox"/> ESL 1 <input type="checkbox"/> ESL 2 <input type="checkbox"/> ESL 3	<input type="checkbox"/> ESL 4 <input type="checkbox"/> ESL 5 <input type="checkbox"/> ESL 6
(10) Have you ever worked in the U.S.? If so specify the employer, the type of job, and the length of the employment.		
(11) Other Employment, Education, or Skills training:		

II. Assessment Form, continued

C. POSSIBLE BARRIERS TO SELF-SUFFICIENCY

The following issues are common barriers to self-sufficiency.

(a) Review each question. (b) In concert with the client, determine if the issue is a barrier for the individual client. (c) Once a barrier has been identified, address the steps to overcome the barrier in the EDP.

(1) Child Care

(a) For children under age 12, who provides childcare when they are not in school?

(b) How many adults in your household or outside your household might be available to provide childcare?

(c) Is childcare a problem which would make it difficult for you to obtain employment?

(d) After consider the questions above, is childcare a barrier to employment?

- ☐ Yes (If Yes, identify action steps to overcome this barrier in the Employability Development Plan (EDP).)
- ☐ No

(2) Health

(a) Have family members had their initial health screening?

- ☐ Yes
- ☐ No

(b) Are any family members receiving treatment for any medical problems? (specify as appropriate)

- ☐ Yes
- ☐ No

(c) Do any of the family members have any major health problems or disabilities?

List any specific problems or disabilities.

II. Assessment Form, continued			
(d) Where have you gone or where would you go for health services?	<input type="checkbox"/> Public Health Clinic	<input type="checkbox"/> Family doctor	<input type="checkbox"/> Emergency Room
	<input type="checkbox"/> HMO	<input type="checkbox"/> Other	<input type="checkbox"/>
(e) After reviewing the questions above, is there a health problem, which would make it difficult for the adult family members to obtain employment?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
(f) If yes, which services can eliminate this barrier? <u>Please identify the services on the EDP plan</u>			
(3) Housing			
(a) My present living situation is	<input type="checkbox"/> House	<input type="checkbox"/> Apartment	<input type="checkbox"/> Hotel/Motel
	<input type="checkbox"/> Rooming House	<input type="checkbox"/> Sharing with relatives	<input type="checkbox"/> Other (specify)
(b) Is housing a problem, which would make it difficult for the adult family members to obtain employment?	<input type="checkbox"/> Yes (explain) <input type="checkbox"/> No		
(c) After reviewing the questions above, is housing a problem, which would make it difficult for the adult family members to obtain employment?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
(d) If yes, which services can eliminate this barrier? <u>Please identify the services on the EDP plan</u>			
(4) Transportation			
(a) What is your primary transportation?	<input type="checkbox"/> Car	<input type="checkbox"/> Bus	<input type="checkbox"/> Other (specify)
(b) Do you have a Wisconsin's Driver's License?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	List any restrictions

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II. Assessment Form, continued	<input type="checkbox"/>	<input type="checkbox"/>	
(c) Do you have a dependable vehicle for work, school, and appointments?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
(d) After reviewing the questions above, is housing a problem, which would make it difficult for the adult family members to obtain employment?	<input type="checkbox"/> Yes	No	
(e) If yes, which services can eliminate this barrier? <u>Please identify the services on the EDP plan</u>			
(5) English Language Training			
(a) Are you currently enrolled in ESL?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
(b) If yes, enter the organization/institution leading the program			
(c) What is your current ESL level?	<input type="checkbox"/> ESL 1 <input type="checkbox"/> ESL 2 <input type="checkbox"/> ESL 3	<input type="checkbox"/> ESL 4 <input type="checkbox"/> ESL 5 <input type="checkbox"/> ESL 6	
(d) After reviewing the questions above, is English language proficiency a problem that would make it difficult for the adult family members to obtain employment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
(e) If yes, which services can eliminate this barrier? <u>Please identify the services on the EDP plan</u>			
(6) Other Barriers. Describe any other barriers that may be identified as barriers to self-sufficiency.			

State of Wisconsin
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Refugee Employment

EMPLOYABILITY DEVELOPMENT PLAN (EDP)

(Please check one) _____ Original _____ Updated

Note: Please complete a separate EDP for each employable adult in the family.

1. Participant Name			2. SSN	
3. Gender	<input type="checkbox"/> Male	<input type="checkbox"/> Female		

SECTION I. EMPLOYMENT GOALS

Goal	Describe the Goal	Date the goal was achieved (became an outcome)	Employment counts towards
A. Primary Goal (Goal A)			<input type="checkbox"/> GT <input type="checkbox"/> GR <input type="checkbox"/> GD <input type="checkbox"/> Does not Count towards PA employment Goal

B. Secondary Goal (Goal B)			<input type="checkbox"/> GT <input type="checkbox"/> GR <input type="checkbox"/> GD <input type="checkbox"/> Does not Count towards PA employment Goal

SECTION II. CASE MANAGEMENT GOALS.

Review the BMRLS Case Management Instructions for assistance in establishing Case Management Goals.

Goal	Describe the Goal	Date the goal was achieved (became an outcome)
C. Primary CM Goal (Goal C)		
D. Secondary CM Goal (Goal D)		

SECTION III. PLAN OF ACTION TO REACH GOALS

A. Identify the action steps to overcome barriers identified in the Section II (Assessment).

B. Record action step activities in the Client Case Log.

Goal (A, B, C, or D)	Actions/ Step:	Describe	Refugee Responsibilities	Agency Responsibilities	Planned Start Date	Planned End Date	Date Completed
	1						
	2						
	3						
	4						
	5						

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This FSP Plan will begin _____/_____/_____ and will end _____/_____/_____
(This period is not to Exceed 6 months, update the plan at least every six months.)

This is my Family self-sufficiency Plan that my refugee service agency representative, _____ and I have developed to help me reach self-sufficiency. I understand that this is my individual plan based upon my current situation. I understand that I can contact the refugee agency at any time, to:

- Update my Family self-sufficiency Plan
- Locate additional resources
- For help in job placements or job upgrades
- Interpretation or translation assistance
- For help in clarifying State and County social service programs (W-2, Food Stamps, Unemployment Insurance, etc.)

I have read this self-sufficiency Plan and understand what is expected of me in the (check the applicable box)

- ☐ **Social Services Program**
- ☐ **Targeted Assistance Program**

Client Signature

Date

Case Manager/Job Developer Signature

Date

Provide 1 copy for the client, 1 copy for the agency file